Basic ICD-9-CM Coding

2006 Edition

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Management Association®

This book includes ICD-9-CM changes announced in the CMS Hospital Inpatient Prospective Payment Systems Proposed Rules, as published in the May 4, 2005 *Federal Register* available at http://www.access.gpo.gov/su_docs/fedreg/a050504c.html. Any additional changes to these codes may be obtained at the CMS Web site or in the Final Rule for IPPS in the *Federal Register* when it is available (usually in August). The official ICD-9-CM addenda are available at: http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines.

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Preface

The coding process requires a range of skills that combines knowledge and practice. *Basic ICD-9-CM Coding* was designed to provide a comprehensive text for students. It introduces the basic principles and conventions of ICD-9-CM coding and illustrates the application of coding principles with examples and exercises based on actual case documentation.

Organization of the Book

The twenty-three chapters of *Basic ICD-9-CM Coding* are organized to cover each section of *ICD-9-CM*. The coding self-test, index, and appendices at the back of the book make information readily accessible and provide additional resources for students.

Basic ICD-9-CM Coding is available with answers or without answers. Please contact the publisher directly if you need a copy of the answer key.

Information Updates

This book must be used with the 2006 edition of *ICD-9-CM* (code changes effective October 1, 2005). It includes the code updates listed in the CMS Hospital Inpatient Prospective Payment Systems Proposed Rules, May 4, 2005 *Federal Register* available at http://www.access.gpo.gov/su_docs/fedreg/a050504c.html.

Every effort has been made to include the most current coding information in this textbook. Because coding is so dynamic, there are continuous changes. In order to keep you informed about some of them, the following information is provided to you.

Coding Guidelines

The ICD-9-CM Official Guidelines for Coding and Reporting, effective April 2005, are included as appendix I of this book. Additional information and updates to current coding guidelines can be found on the following Web site: www.cdc.gov/nchs/icd9.htm.

Classification of Death and Injury Resulting from Terrorism

Because of the events of September 11, 2001, there is a need to be able to classify, report, and analyze injuries and deaths associated with terrorism. Codes have been developed for both ICD-10 and ICD-9-CM. These codes, which were published in the *Federal Register* in May 2002

and became effective October 1, 2002, are available at www.cdc.gov/nchs/about/otheract/icd9/terrorism-_code.htm.

ICD-9-CM Procedure Codes

In order to provide an expedited process for the approval of procedure codes, the Centers for Medicare and Medicaid Services (CMS) now allows procedures approved at the spring Coordination and Maintenance Committee meeting to fast-track with the codes effective October 1 of each year. Because they are not discussed until the spring, these codes are not included in the final codes listed in the May *Federal Register.* The codes listed in the May 4, 2005 *Federal Register* are included in this updated textbook. They are available at http://www.access.gpo.gov/su_docs/fedreg/a050504c.html. Additional procedure codes that are effective October 1, 2005, may be listed in the August Final Rule, which will be published in the *Federal Register.*

Additional Practice

AHIMA's publication *Clinical Coding Workout* is an excellent follow-up resource after the coder completes *Basic ICD-9-CM Coding.* Containing beginning, intermediate, and advanced exercises, it is also a perfect teaching tool for coders wanting to sharpen their ability to make critical coding decisions. The book is made up entirely of case studies that help students and coders alike understand what they need to know when it comes to correct coding practices and procedures. The case studies in the book require users to make the kinds of decisions that coding professionals must make every day on the job.

Chapter 1

Introduction to ICD-9-CM

What Is Coding?

In its simplest form, coding is the transformation of verbal descriptions into numbers. We are all very familiar with this task because we use codes every day to carry out simple business and personal transactions. For example, when we use a zip code in addressing a letter, we are transforming a street address into numbers.

In the healthcare arena, specific codes describe diseases, injuries, and procedures. Whereas assigning a zip code is a rather simple activity, the assignment of diagnostic and procedural codes requires a detailed thought process that is supported by a thorough knowledge of medical terminology, anatomy, and pathophysiology.

How Are Codes Assigned, and What System Is Used?

Hospitals and other healthcare facilities index healthcare data by referring and adhering to a classification system published by the U.S. Department of Health and Human Services: *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).* As the title states, ICD-9-CM has been revised nine times, giving evidence to the fact that the system has been in use for many years.

The notion of employing classification systems can be traced back to the time of the ancient Greeks. In the seventeenth century, English statistician John Graunt developed the London Bills of Mortality, which provided the first documentation of the proportion of children who died before reaching age six. In 1838, William Farr, the registrar general of England, developed a system to classify deaths. In 1893, a French physician, Jacques Bertillon, introduced the Bertillon Classification of Causes of Death at the International Statistical Institute in Chicago.

Several countries subsequently adopted Dr. Bertillon's system; and in 1898, the American Public Health Association (APHA) recommended that the registrars of Canada, Mexico, and the United States also adopt it. In addition, APHA recommended revising the system every ten years so as to remain current with medical practice. As a result, the first international conference to revise the International Classification of Causes of Death convened in 1900; subsequent revisions occurred every ten years. At that time, the classification system was contained

in one book, which included an Alphabetic Index as well as a Tabular List. The book was quite small compared with current coding texts.

The revisions that followed contained minor changes; however, the sixth revision of the classification system brought drastic changes, as well as an expansion into two volumes. The sixth revision included morbidity and mortality conditions, and its title was modified to reflect these changes: *Manual of International Statistical Classification of Diseases, Injuries and Causes of Death (ICD).* Prior to the sixth revision, responsibility for ICD revisions fell to the Mixed Commission, a group composed of representatives from the International Statistical Institute and the Health Organization of the League of Nations. In 1948, the World Health Organization (WHO), with headquarters in Geneva, Switzerland, assumed responsibility for preparing and publishing the revisions to ICD every ten years. WHO sponsored the seventh and eighth revisions in 1957 and 1968, respectively.

The entire history of coding emphasizes the determination of many people to provide an international classification system for compiling and presenting statistical data. ICD now has become the most widely used statistical classification system in the world. Although some countries found ICD sufficient for hospital indexing purposes, many others felt that it did not provide adequate detail for diagnostic indexing. In addition, the original revisions of ICD did not provide for classification of operative and diagnostic procedures. As a result, interested persons in the United States began to develop their own adaptation of ICD for use in this country.

In 1959, the U.S. Public Health Service published *The International Classification of Diseases, Adapted for Indexing of Hospital Records and Operation Classification (ICDA).* Completed in 1962, a revision of this adaptation—considered to be the seventh revision of ICD—expanded a number of areas to more completely meet the indexing needs of hospitals. The U.S. Public Health Service later published the *Eighth Revision, International Classification of Diseases, Adapted for Use in the United States.* Commonly referred to as ICDA-8, this classification system fulfilled its purpose to code diagnostic and operative procedural data for official morbidity and mortality statistics in the United States.

WHO published the ninth revision of ICD (ICD-9) in 1978. The U.S. Public Health Service modified ICD-9 to meet the needs of American hospitals and called it *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).* The ninth revision expanded the book to three volumes and introduced a fifth-digit subclassification.

ICD-10-CM and ICD-10-PCS

The National Center for Health Statistics (NCHS), the federal agency responsible for the use of the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)* in the United States, has developed a clinical modification of the classification for morbidity purposes. The new ICD-10-CM would be used for the reporting of diseases and conditions of patients treated in the United States healthcare system. For the coding of death certificates (mortality data), ICD-10 replaced ICD-9 as of January 1, 1999. ICD-10-CM is intended to be the replacement for ICD-9-CM, volumes 1 and 2.

ICD-10 is copyrighted by the World Health Organization (WHO), which owns and publishes the classification. WHO authorized the development of the adaption of ICD-10 for use in the United States. All modifications to ICD-10 must conform to WHO conventions for ICD.

ICD-10-CM was developed following a thorough evaluation by a Technical Advisory Panel and extensive additional consultation with physician groups, clinical coders, and others to ensure clinical accuracy and utility. NCHS believes the clinical modification represents a significant improvement over ICD-9-CM and ICD-10.

The current draft of ICD-10-CM contains significantly more codes than exist in ICD-9-CM and offers many additional advantages. Some of these features include:

- ICD-10-CM has the same hierarchical structure as ICD-9-CM, but the codes are all alphanumeric and all letters except U are used.
- The codes corresponding to ICD-9-CM V and E codes are incorporated into the main classification and are not separated into supplementary classifications as in ICD-9-CM.
- New diseases and conditions not uniquely identified in ICD-9-CM have been given codes. In addition, conditions with newly discovered etiology or treatment protocols have been reclassified to a more appropriate chapter.
- Injuries are grouped by body part instead of by categories of injury.
- Excludes notes are expanded to provide guidance on the hierarchy of chapters and to clarify priority of code assignment.
- Combination codes have been created, such as arteriosclerotic heart disease with angina.
- The concept of laterality (right–left) has been added.
- The codes for postoperative complications have been expanded, and a distinction has been made between intraoperative complications and postprocedural disorders.
- The obstetric codes indicate which trimester the patient is in and no longer identify whether the patient has delivered.
- The diabetes codes indicate insulin-requiring and non-insulin-requiring types.
- Information relevant to ambulatory and managed care encounters has been added.
- In general, the classification allows greater specificity in code assignment.

The draft revision of ICD-10-CM is available on the NCHS Web site, Classifications of Diseases and Functioning and Disability home page, at www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm. The codes in ICD-10-CM are not currently valid for any purpose or use. Testing of ICD-10-CM will continue, based on the draft version. It is anticipated that updates to the draft will occur prior to implementation of ICD-10-CM.

As of early 2005, there is no anticipated implementation date for ICD-10-CM. For ICD-10-CM to be implemented, it must be recommended by the Secretary of Health and Human Services as a replacement for the ICD-9-CM diagnosis code set national standard. Once this is done, implementation will be based on the process for adoption of standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). There will be at least a two-year implementation window once the final notice to implement has been published in the *Federal Register*. This notice is anticipated to propose naming ICD-10-CM for diagnoses in all healthcare settings and ICD-10-PCS to replace volume 3 of ICD-9-CM for procedures in the hospital inpatient setting only.

ICD-10-PCS has been under development by the Centers for Medicare and Medicaid Services (CMS) for a number of years. It is intended to replace ICD-9-CM, volume 3, for the reporting of hospital inpatient procedures. It is believed to be a significant improvement over ICD-9-CM, volume 3, in terms of its comprehensiveness and expandability.

ICD-10-PCS has a multiaxial, seven-character, alphanumeric code structure, which provides a unique code for all substantially different procedures and allows new procedures to be easily incorporated as new codes. Procedures in ICD-10-PCS are divided into sections that relate to the general type of procedure. The first character of the procedure codes always specifies the section or type of procedure. The second through seventh characters have a standard meaning within each section but may have a different meaning across sections. In ICD-10-PCS, the term *procedure* is used to refer to the complete specification of the seven characters. All terminology in ICD-10-PCS is precisely defined, with a specific meaning attached to all terms used in the system.

ICD-10-PCS continues to be refined and updated awaiting the final decision from the Department of Health and Human Services on whether it will propose adoption of ICD-10-CM and ICD-10-PCS as a HIPAA standard. The previous training manual has been updated by a new reference manual that includes definitions for PCS terms, root operations and approaches, and draft PCS coding guidelines. Plans for 2006 include completion of the ICD-9-CM to ICD-10-PCS crosswalk and work on the task of converting the DRGs into ICD-10-CM and PCS. The goal is to complete a prototype of the DRGs in the new code sets by the end of 2005. The latest updates are available on the CMS Web site at http://cms.hhs.gov/paymentsystems/icd9/icd10.asp

Although it is likely that the new coding system will require coders to have more knowledge of anatomy and physiology, as well as requiring complete documentation of a procedure to be available prior to coding, ICD-10-PCS appears to provide more complete and accurate descriptions of the procedures performed than does ICD-9-CM, volume 3. All procedures on a particular body part, by a particular approach, or by another characteristic can be easily retrieved using ICD-10-PCS data. The codes will provide very specific information about a particular procedure.

Additional readings on ICD-10-CM and ICD-10-PCS can be found in appendix G of this book. A description of ICD-10 can be found at the Web site for the World Health Organization (WHO) (www.who.int/whosis/icd10/index.html). For more information on the versions that will be implemented in the United States, watch the Web sites for NCHS (www.cdc.gov/nchs) and CMS (www.CMS.gov), in addition to AHIMA's site (www.ahima.org).

Proposals to consider the new coding systems (ICD-10-CM and ICD-10-PCS) as national standards must take place within the federal government's administrative simplification process. The administrative simplification requirements of the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, require the establishment of national standards for code sets. HIPAA requires a proposed and final notice establishing initial national code sets. The initial code sets will become the national standards at least two years after publication of the final notice. No notices have been published regarding ICD-10-CM and ICD-10-PCS.

HIPAA Electronic Transactions and Coding Standards Rule

On August 17, 2000, the U.S. Department of Health and Human Services (DHHS) published the final regulations for electronic transactions and coding standards as established under HIPAA in the *Federal Register* (65 FR 50312). The final rule designated five medical code standards to be used initially under the HIPAA rule. These included:

- *International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM),* Volumes 1 and 2

- *International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM),* Volume 3
- *Current Procedural Terminology, 4th Edition (CPT-4)*
- *Healthcare Common Procedure Coding System (HCPCS)*
- *Code on Dental Procedures and Nomenclatures, 2nd Edition (CDT-2)*
- *National Drug Codes (NDC)*

On February 20, 2003, the DHHS published a final rule in the *Federal Register* (68 FR 8381) that repealed the adoption of the *National Drug Codes (NDC)* for institutional and professional claims. It did allow the NDC to remain the standard medical data code set for reporting drugs and biologics for retail pharmacy claims. The intent of this decision was to give covered entities the choice in determining which code set to use with respect to payment of claims, including HCPCS and NDC codes. Hospitals and physicians are likely to continue using HCPCS. As a result of this repeal, there is no identified standard medical data code set in place for reporting drugs and biologics on non–retail pharmacy transactions. Covered entities could use HCPCS or NDC as the preferred and agreed-upon code set with their trading partners.

The ICD-9-CM Official Guidelines for Coding and Reporting were named as a required component of the ICD-9-CM code set in the final rule for electronic transactions and coding standards (65 FR 50323). This makes adherence to the ICD-9-CM guidelines a requirement for compliance with the rule. No other set of coding guidelines was specified in the coding standards.

The original deadline for compliance with the electronic transactions rule was October 16, 2002, for all covered entities except small health plans, which by law had an additional year. However, in January 2002, in the Administrative Simplification Compliance Act, Congress authorized a one-year extension, to October 16, 2003, for those covered entities required to comply in 2002.

As noted above, the final rule identified five medical code sets. Although it is true that most of the code sets adopted are in current use, some changes have been made regarding their use and context. It is important to note that, upon implementation, these medical code sets will become the rule for nearly all insurance payers.

ICD-9-CM, volumes 1 and 2, will cover diseases, injuries, impairments, and other health problems and their manifestations, as well as causes of injury and disease impairment. Essentially, this part of the rule maintains the status quo.

ICD-9-CM, volume 3, Procedures, has been limited to procedures or other actions taken for diseases, injuries, and impairments of hospital *inpatients* reported by hospitals and related to prevention, diagnosis, treatment, and management. This means that nonacute facilities will no longer be able to use volume 3 to report procedures and will, instead, have to use CPT-4 or HCPCS codes as appropriate.

The combination of HCPCS and CPT-4 will continue to be used for physicians and other healthcare services, such as hospital outpatient services. These services include, but are not limited to, physician services, physical and occupational therapy services, radiological services, clinical laboratory tests, other medical diagnostic procedures, hearing and vision services, and transportation services, including ambulances.

The rule makes it clear that the use of ICD-9-CM procedure codes is restricted to the reporting of inpatient procedures by hospitals and that the combination of CPT-4 and HCPCS Level 2 codes will be used by physicians and other healthcare services. There is no clear commitment to resolve duplication and overlap between CPT-4 and HCPCS Level 2 codes, such as the G codes in HCPCS that duplicate services described by CPT-4.

More information about the medical code sets and other facts about the HIPAA transactions and code sets final rule can be found on the AHIMA Web site (www.ahima.org) or in the published final rule in the August 17, 2000 *Federal Register* (volume 65, number 160, pages 50312–50372). The *Federal Register* may be accessed from the Government Printing Office Web site at www.access.gpo.gov/su_docs/fedreg/a000817c.html.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was signed into law by President George W. Bush on December 8, 2003. Section 503 of the bill includes language concerning the timeliness of data collection and contains the following clause, which affects the updating of ICD-9-CM:

> Sec. 503 Recognition of New Medical Technology Under Inpatient Hospital Prospective Payment System, (a) Improving Timeliness of Data Collection, (vii) Under the mechanism of this new subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.

This means that, beginning in 2005, ICD-9-CM diagnosis and procedure codes could be issued to be effective twice a year, April 1 and October 1. The DRG software and Medicare Code Editor will have to be updated twice a year, as will all the coding software vendor products and healthcare providers' information systems for capturing data and processing information.

The Centers for Medicare and Medicaid Services (CMS) discussed a proposal to accomplish this new congressional requirement in the Notice of Proposed and Final Rulemaking for the Hospital Inpatient Payment System. Information on this April 1 update process can be found in the Final Rule published August 11, 2004 (69 FR 48954), beginning on page 48954. In general, new diagnosis and procedure codes will be implemented on October 1 as has been the standard practice. However, consideration will be given to implementing new codes on April 1 if a strong and convincing case is made by the requestor at the ICD-9-CM Coordination and Maintenance Committee meeting that the new code is needed to describe new technologies. Otherwise, the codes will be considered for the next October 1 implementation. A number of organizations have expressed concerns about the impact of the April 1 ICD-9-CM coding update on providers. There were no requests for an ICD-9-CM code to be implemented April 1, 2005.

Official Addendum to ICD-9-CM

ICD-9-CM represents the most current and comprehensive statistical classification system of its kind. Compared with international ICD updates that occur approximately every ten years, ICD-9-CM undergoes annual updates in the United States to remain current. Codes may be added, revised, or deleted. An *Official Authorized Addendum* documents the changes, which are effective October 1 of each year. CMS and NCHS publish the addenda with the approval of WHO. NCHS is responsible for maintaining the diagnosis classification—volumes 1 and 2; CMS is responsible for maintaining the procedure classification—volume 3. The American Health

Information Management Association (AHIMA) and the American Hospital Association (AHA) give advice and assistance, as do HIM practitioners, physicians, and other users of ICD-9-CM.

A point to remember: To ensure accurate coding, all ICD-9-CM coding books *must* be updated yearly with ICD-9-CM revisions. In addition, all coding software (encoders) must be updated. As a general rule, new ICD-9-CM codes are effective October 1 of each year.

Characteristics of ICD-9-CM

As it has since the October 1991 publication by the U.S. Department of Health and Human Services, the single, official ICD-9-CM codebook currently comprises three volumes:

Volume 1: Tabular List of Diseases and Injuries
Volume 2: Alphabetic Index to Diseases
Volume 3: Tabular List and Alphabetic Index to Procedures

The official ICD-9-CM is available only on CD-ROM from the U.S. Government Printing Office in Washington, DC ([800] 512-1800).

A copyright of ICD-9-CM does not exist, so many versions of the codebook appear on the market. Although each book may offer special features, the ICD-9-CM codes themselves remain the same. This workbook, *Basic ICD-9-CM Coding,* refers to the official ICD-9-CM codebook throughout its text.

Because ICD-9-CM is reviewed annually, it is important to remember that all ICD-9-CM codebooks must be kept current to reflect the revisions, deletions, and additions of codes that are generally implemented in the United States on October 1 of each year.

Volume 1: Tabular List of Diseases and Injuries

The Tabular List of Diseases and Injuries (volume 1) contains the following major subdivisions:

Classification of Diseases and Injuries
Supplementary Classifications (V Codes and E Codes)
Appendices

Classification of Diseases and Injuries

Volume 1, Classification of Diseases and Injuries, contains seventeen chapters that classify conditions according to etiology (cause of disease) or by specific anatomical (body) system.

EXAMPLE: Chapter 1, Infectious and Parasitic Diseases, represents classification by etiology or cause of disease.

Chapter 7, Diseases of the Circulatory System, represents classification by anatomical system.

The Tabular List contains the following seventeen chapters:

	Chapter Titles	Categories
1.	Infectious and Parasitic Diseases	001–139
2.	Neoplasms	140–239
3.	Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders	240–279
4.	Diseases of the Blood and Blood-Forming Organs	280–289
5.	Mental Disorders	290–319
6.	Diseases of the Nervous System and Sense Organs	320–389
7.	Diseases of the Circulatory System	390–459
8.	Diseases of the Respiratory System	460–519
9.	Diseases of the Digestive System	520–579
10.	Diseases of the Genitourinary System	580–629
11.	Complications of Pregnancy, Childbirth, and the Puerperium	630–677
12.	Diseases of the Skin and Subcutaneous Tissue	680–709
13.	Diseases of the Musculoskeletal System and Connective Tissue	710–739
14.	Congenital Anomalies	740–759
15.	Certain Conditions Originating in the Perinatal Period	760–779
16.	Symptoms, Signs, and Ill-Defined Conditions	780–799
17.	Injury and Poisoning	800–999

Format

Each chapter of volume 1 is structured into the following subdivisions: sections, categories, and subcategories.

Sections

A section consists of a group of three-digit categories that represent a single disease entity, or a group of similar or closely related conditions.

DISORDERS OF THE THYROID GLAND (240–246)

Categories

A three-digit category represents a single disease entity, or a group of similar or closely related conditions.

520 Disorders of tooth development and eruption

Subcategories

The fourth-digit subcategory provides more specificity or information regarding the etiology (cause of a disease or illness), site (location), or manifestation (display of characteristic signs,

symptoms, or secondary processes of a disease or illness). Fourth-digit subcategories are collapsible to the three-digit level.

A three-digit code cannot be assigned if a category has been subdivided and fourth digits are available.

476 Chronic laryngitis and laryngotracheitis

476.0 Chronic laryngitis
Laryngitis:
catarrhal
hypertrophic
sicca

476.1 Chronic laryngotracheitis
Laryngitis, chronic, with tracheitis (chronic)
Tracheitis, chronic, with laryngitis

Exercise 1.1

Turn to code 055, Measles, in volume 1 (Tabular List) to answer the following questions:

1. Is code 055 a category or a subcategory?

2. What is the subcategory code for measles without complications?

3. What do the subcategory codes represent?

4. Are the subcategories manifestations, sites, or causes of the disease?

5. In what chapter and section is code 055 located?

Fifth-Digit Subclassifications

In some cases, fourth-digit subcategories have been expanded to the fifth-digit level to provide even greater specificity. Fifth-digit assignments and instructions can appear at the beginning of a chapter, a section, a three-digit category, or a fourth-digit category, as illustrated below.

At the chapter level: An instruction at the beginning of chapter 13, Diseases of the Musculoskeletal System and Connective Tissue (710–739), states that certain categories must be assigned a fifth digit to describe the affected body site. Fifth-digit assignments and instructions appearing at the beginning of this chapter are shown in the following illustration:

13. DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE (710–739)

The following fifth-digit subclassification is for use with categories 711–712, 715–716, 718–719, and 730:

0	**site unspecified**	
1	**shoulder region**	
	Acromioclavicular	Joint(s)
	Glenohumeral	
	Sternoclavicular	
	Clavicle	
	Scapula	
2	**upper arm**	
	Elbow joint	Humerus
3	**forearm**	
	Radius	Wrist joint
	Ulna	
4	**hand**	
	Carpus	Phalanges [fingers]
	Metacarpus	
5	**pelvic region and thigh**	
	Buttock	Hip (joint)
	Femur	
6	**lower leg**	
	Fibula	Patella
	Knee joint	Tibia
7	**ankle and foot**	
	Ankle joint	Phalanges, foot
	Digits [toes]	Tarsus
	Metatarsus	Other joints in foot
8	**other specified sites**	
	Head	Skull
	Neck	Trunk
	Ribs	Vertebral column
9	**multiple sites**	

At the section level: Information at the beginning of section 200–208, Malignant Neoplasm of Lymphatic and Hematopoietic Tissue, notes that a fifth digit must be assigned to categories 200 through 202 to describe the site of the lymph nodes involved. Fifth-digit assignments and instructions appearing at the beginning of this section are shown in the following illustration:

MALIGNANT NEOPLASM OF LYMPHATIC AND HEMATOPOIETIC TISSUE (200–208)

Excludes: *secondary neoplasm of:*
bone marrow (198.5)
spleen (197.8)
secondary and unspecified neoplasm of lymph nodes (196.0–196.9)

The following fifth-digit subclassification is for use with categories 200–202:

0 unspecified site, extranodal and solid organ sites
1 lymph nodes of head, face, and neck
2 intrathoracic lymph nodes
3 intra-abdominal lymph nodes
4 lymph nodes of axilla and upper limb
5 lymph nodes of inguinal region and lower limb
6 intrapelvic lymph nodes
7 spleen
8 lymph nodes of multiple sites

At the three-digit category level: An instruction from the beginning of category 250, Diabetes mellitus, states that a fifth digit should be assigned to describe the type of diabetes mellitus. Fifth-digit assignments and instructions appearing at the beginning of this three-digit category are shown in the following illustration:

250 Diabetes mellitus

Excludes: *gestational diabetes (648.8)*
hyperglycemia, NOS (790.6)
neonatal diabetes mellitus (775.1)
nonclinical diabetes (790.29)

The following fifth-digit subclassification is for use with category 250:

0 type II or unspecified type, not stated as uncontrolled

Fifth-digit 0 is for use for type II patients, even if the patient requires insulin

Use additional code, if applicable, for associated long-term (current) insulin use, V58.67

1 type I [juvenile type], not stated as uncontrolled

2 type II or unspecified type, uncontrolled

Fifth-digit 2 is for use for type II patients, even if the patient requires insulin

Use additional code, if applicable, for associated long-term (current) insulin use, V58.67

3 type I [juvenile type], uncontrolled

At the fourth-digit subcategory level: The fourth-digit subcategory 786.5, Chest pain, is further subdivided to the fifth-digit level to describe specific types of chest pain. Fifth-digit assignments and instructions appearing at the beginning of this fourth-digit subcategory are shown in the following illustration:

786.5 Chest pain

786.50 Chest pain, unspecified

786.51 Precordial pain

786.52 Painful respiration
Pain:
anterior chest wall
pleuritic
Pleurodynia

Excludes: *epidemic pleurodynia (074.1)*

786.59 Other
Discomfort, Pressure, Tightness } in chest

Excludes: *pain in breast (611.71)*

A point to remember: The use of fifth digits is *not* optional. Fifth digits are quite easy to overlook. To remember to assign fifth digits, it is helpful to highlight all the fourth-digit subcategories requiring a fifth-digit subclassification in volume 1 of ICD-9-CM. Many publishers include special symbols and/or color highlighting to identify codes requiring fourth and/or fifth digits.

Exercise 1.2

In volume 1 (Tabular List) of ICD-9-CM, turn to the section titled "Malignant Neoplasm of Lymphatic and Hematopoietic Tissue," which begins with code 200, to answer questions 1 through 3. Then turn to category code 820, Fracture of neck of femur, to answer questions 4 and 5.

1. Identify the correct fifth digit for a patient with Hodgkin's sarcoma (201.2) with involvement of the intrapelvic lymph nodes. _____

2. Identify the correct fifth digit for a patient with Burkitt's tumor (200.2) of the intra-abdominal lymph nodes. _____

3. Identify the correct fifth digit for a patient with nodular lymphoma (202.0) with involvement of lymph nodes of multiple sites. _____

4. Identify the code for a patient with a closed transcervical fracture of the epiphysis. _____

5. Identify the code for a patient with an open fracture of the neck of the femur, with the actual site unspecified. _____

Residual Subcategories

Residual subcategories are codes with titles of "other" and "unspecified." They were developed to classify conditions not assigned a separate subcategory, thus ensuring that every disease always has a code. Residual subcategories titled "other" are easily distinguished because the

fourth digit is often the number 8. Those codes describing "unspecified" conditions are usually assigned a fourth digit of 9.

003.8 Other specified salmonella infections
003.9 Salmonella infection, unspecified

In the preceding example, code 003.8 would include all other specified types of salmonella infections, excluding those listed in codes 003.0 through 003.29. But code 003.9 is assigned when the physician documents a diagnosis of salmonella infection without further specification.

However, in a few instances, fourth digit 9 is assigned for both "other" and "unspecified" because digits 0 through 8 have been used.

478.9 Other and unspecified diseases of upper respiratory tract

Abscess, Cicatrix } of trachea

Codes 478.0 through 478.8 are used to describe specific upper respiratory tract diseases. However, code 478.9 includes both unspecified diseases and other diseases not classified in subcategories 478.0 through 478.8.

Supplementary Classifications

Two supplementary classifications exist in addition to the main classification for diseases and injuries. Unlike the numeric codes in the disease classification, the supplementary classifications contain alphanumeric codes.

Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01–V84)—V Codes

V codes consist of the alphabetic character V followed by two numeric digits, a decimal point, a fourth digit, and, where applicable, a fifth digit.

V64 Persons encountering health services for specific procedures, not carried out

- V64.0 Vaccination not carried out because of contraindication
- V64.1 Surgical or other procedure not carried out because of contraindication
- V64.2 Surgical or other procedure not carried out because of patient's decision
- V64.3 Procedure not carried out for other reasons
- V64.41 Laparoscopic surgical procedure converted to open procedure
- V64.42 Thoracoscopic surgical procedure converted to open procedure
- V64.43 Arthroscopic surgical procedure converted to open procedure

Supplementary Classification of External Causes of Injury and Poisoning (E800–E999)—E Codes

E codes consist of the alphabetic character E followed by three numeric digits, a decimal point, and a fourth digit.

E953	**Suicide and self-inflicted injury by hanging, strangulation, and suffocation**
E953.0	**Hanging**
E953.1	**Suffocation by plastic bag**
E953.8	**Other specified means**
E953.9	**Unspecified means**

Both supplementary classifications (E codes and V codes) are discussed in detail later in this book. E codes are discussed in chapter 21; V codes are discussed in chapter 23.

Appendices

Volume 1 of ICD-9-CM has traditionally included five appendices. Changes in the mental disorders codes, as described below, have resulted in the deletion of appendix B in October 2004 and subsequent publications.

Appendix A: Morphology of Neoplasms

Appendix A includes a listing of all morphology types with the appropriate morphology, or M code. Chapter 5 of this book describes morphology codes, or M codes, in greater detail.

Appendix B: Glossary of Mental Disorders (Deleted)

In 2003 and prior years, the Glossary of Mental Disorders included definitions for the psychiatric terms found in chapter 5, Mental Disorders, of ICD-9-CM. However, this appendix was not maintained for many years and was considered to contain many inaccuracies. In response to a request from the American Psychiatric Association, the Glossary of Mental Disorders was removed from the official government (CD-ROM) version of ICD-9-CM, effective with the October 1, 2004 update. Coders should refer to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR),* published by the American Psychiatric Association, for definitions of the mental disorders classified in chapter 5 of ICD-9-CM.

Appendix C: Classification of Drugs by the American Hospital Formulary Service List

The classification of drugs by the American Hospital Formulary Service (AHFS) list is published by the American Society of Hospital Pharmacists. It categorizes drugs to family-related groups. When coders must locate the category of a new drug or cannot find a new drug in the Table of Drugs and Chemicals, they turn to the AHFS list as a helpful reference. The Table of Drugs and Chemicals lists the AHFS number under the main term "Drug." Appendix C of ICD-9-CM includes a listing of the AHFS categories and the appropriate ICD-9-CM code.

Appendix D: Classification of Industrial Accidents according to Agency

Appendix D classifies industrial accidents according to agency (machines, equipment, radiation, and so forth), as adopted by the Tenth International Conference of Labor Statisticians on October 12, 1962.

Appendix E: List of Three-Digit Categories

Appendix E includes a listing of each three-digit category in ICD-9-CM, along with the appropriate title of each.

Volume 2: Alphabetic Index to Diseases

Volume 2 contains the following major sections:

Index to Diseases and Injuries
Table of Drugs and Chemicals
Alphabetic Index to External Causes of Injury and Poisoning (E Codes)

Index to Diseases and Injuries

The Index to Diseases and Injuries includes the terminology for all the codes appearing in volume 1 (Tabular List) of ICD-9-CM. The Alphabetic Index employs three levels of indentations:

Main terms
Subterms
Carryover lines

Main Terms

Printed in boldface type, main terms are set flush with the left margin of each column for easy reference. They may represent the following:

- Diseases: influenza, bronchitis
- Conditions: fatigue, fracture, injury
- Nouns: disease, disturbance, syndrome
- Adjectives: double, large, kink

Instead of a listing of subterms or codes, ICD-9-CM provides anatomical terms with a cross-reference that directs the coder to reference the condition. For example, bronchial asthma is found under the disease term "asthma" rather than the site "bronchial."

A point to remember: Many conditions are found in more than one place in the Alphabetic Index; for example:

- Complications of medical or surgical care are indexed under the name of the condition, as well as the main term "Complications."
- Obstetrical conditions are found under the name of the condition and/or under main terms such as "Delivery," "Labor," "Pregnancy," and "Puerperal" (after delivery).
- Conditions that include the term *disease* or *syndrome* in their titles or descriptions may be found under "Disease" or "Syndrome," as well as under the disease or syndrome's name. For example, chronic obstructive lung disease may be found in the Alphabetic Index under "Obstructive," as well as under "Disease."

Exercise 1.3

Using the Alphabetic Index, underline the main term in each of the following:

1. Breast mass
2. Primary hydronephrosis
3. Deviated nasal septum
4. Inguinal adenopathy
5. Arteriosclerotic heart disease

Subterms

Some main terms are followed by a list of indented subterms (modifiers) that affect the selection of an appropriate code for a given diagnosis. The subterms form individual line entries arranged in alphabetical order and printed in regular type beginning with a lowercase letter. Subterms are indented one standard indentation to the right under the main term. They describe essential differences in site, cause, or clinical type. More specific subterms are indented farther to the right, as needed; indented one standard indentation after the preceding subterm; and listed in alphabetical order.

Prior to selecting a code, all subentries following the main term should be reviewed to determine the appropriate code. Note that the terms *with* and *without* are listed at the beginning of all the subterms, rather than in alphabetical order.

Incontinence 788.30 ← **Main Term**
- without sensory awareness 788.34
- anal sphincter 787.6 ← **Site**
- continuous leakage 788.37
- feces 787.6
  - due to hysteria 300.11
  - nonorganic origin 307.7
- hysterical 300.11
- mixed (male) (female) (urge and stress) 788.33
- overflow 788.39
- paradoxical 788.39
- rectal 787.6
- specified NEC 788.39
- stress (female) 625.6 ← **Cause**
  - male NEC 788.32
- urethral sphincter 599.84
- urge 788.31
  - and stress (male) (female) 788.33
- urine 788.30
  - active 788.30 ← **Clinical Type**
  - male 788.30
    - stress 788.32
      - and urge 788.33
  - neurogenic 788.39
  - nonorganic origin 307.6
  - stress (female) 625.6
    - male NEC 788.32
  - urge 788.31
    - and stress 788.33

Carryover Lines

Carryover lines are needed because the number of words that can fit on a single line of print in the Alphabetic Index is limited. They are indented two indents from the preceding line. Coders must be careful to avoid confusing carryover lines with subterm entries. Careful reading is essential.

Rubella (German measles) 056.9
complicating pregnancy, childbirth, or puerperium 647.5

Exercise 1.4

Using the Alphabetic Index only, assign codes to the following:

1. Tension headache

2. Suppurative pancreatitis

3. Neonatal tooth eruption

4. Infectious endocarditis

5. Mitral endocarditis with active aortic disease

Nonessential Modifiers

Nonessential modifiers are a series of terms in parentheses that sometimes directly follow main terms, as well as subterms. The presence or absence of these parenthetical terms in the diagnosis has no effect on the selection of the code listed for that main term or subterm.

Pneumonia (acute) (Alpenstich) (benign) (bilateral) (brain) (cerebral) (circumscribed) (congestive) (creeping) (delayed resolution) (double) (epidemic) (fever) (flash) (fulminant) (fungoid) (granulomatous) (hemorrhagic) (incipient) (infantile) (infectious) (infiltration) (insular) (intermittent) (latent) (lobe) (migratory) (newborn) (organized) (overwhelming) (primary) (progressive) (pseudolobar) (purulent) (resolved) (secondary) (senile) (septic) (suppurative) (terminal) (true) (unresolved) (vesicular) **486**

EXAMPLE:

1. Mike Rogers was seen by Dr. Moore and diagnosed with congestive pneumonia. The appropriate code assignment is 486. ("Congestive" is a nonessential modifier.)
2. Cindy Stevens was seen by Dr. Smith and diagnosed with pneumonia. The appropriate code assignment is 486. (Nonessential modifier is not stated.)

In the preceding patient examples, the presence or absence of a nonessential modifier in the diagnostic statement did not affect the code that was selected.

Exercise 1.5

Using the Alphabetic Index only, underline the term that is the nonessential modifier in each of the following diagnostic statements and then assign a code to each condition:

1. Congenital distortion of chest wall _____
2. Ruptured diverticula of cecum _____
3. Bleeding external hemorrhoids of rectum _____
4. Surgical menopausal syndrome _____
5. Acute urethritis _____

Eponyms

Many diseases and operations carry the name of a person, or an eponym. An eponym is defined by *Stedman's Medical Dictionary* as: "The name of a disease, structure, operation, or procedure, usually derived from the name of the person who discovered or described it first" (Stedman 2000, 611). The main terms for eponyms are located in the Alphabetic Index as follows:

1. Under the eponym itself

Alzheimer's
disease or sclerosis 331.0

2. Under main terms such as disease, syndrome, and disorder

Disease . . .
Alzheimer's—*see* Alzheimer's

3. With description of the disease or syndrome, usually enclosed in parentheses, but sometimes following the eponym

Chiari's
disease or syndrome (hepatic vein thrombosis) 453.0

Exercise 1.6

Using the Alphabetic Index only, assign codes to the following:

1. Briquet's disorder

2. Lou Gehrig's disease

3. Stokes-Adams syndrome

4. Sprengel's deformity

5. Erb's disease

Terms Not Listed in the Tabular List

Occasionally, a diagnostic or procedure term located in the Alphabetic Index is not included in the Tabular List. In these situations, only similar terms are listed and the guidance of the Alphabetic Index should be trusted.

EXAMPLE: The condition *listlessness* is included in the Alphabetic Index with a code assignment of 780.79. In reviewing the Tabular List to verify the accuracy of the code, the following is noted:

780.7 Malaise and fatigue

Excludes: *debility, unspecified (799.3)*
fatigue (during):
combat (308.0–308.9)
heat (992.6)
pregnancy (646.8)
neurasthenia (300.5)
senile asthenia (797)

780.71 Chronic fatigue syndrome

780.79 Other malaise and fatigue

Asthenia NOS
Lethargy
Postviral (asthenic) syndrome
Tiredness

Although the Alphabetic Index assigns 780.79 as the code for listlessness, that particular term is not included in the Tabular List description, but similar terms are given. Always trust the guidance of the Alphabetic Index in such cases.

Index Tables

The following main entries in the Alphabetic Index to Diseases have subterms arranged in tables:

- Hypertension
- Neoplasm

Using tables for these terms simplifies access to complex combinations of subterms. These index tables are discussed in detail in other chapters of this book.

Conventions in ICD-9-CM

To assign diagnostic and procedure codes accurately, a thorough understanding of ICD-9-CM conventions is necessary. All three volumes of ICD-9-CM adhere to most of the conventions addressed next, with the exception of volume 3 where slight variations occur. (Chapter 2 in *Basic ICD-9-CM Coding* discusses these variations.)

Cross-Reference Terms

Cross-references are used in the Alphabetic Index as directions to look elsewhere in the codebook before assigning a code. Three types of cross-reference terms appear in the Alphabetic Index: *see, see also,* and *see category.*

See

The *see* cross-reference points to an alternative term. This mandatory instruction must be followed to ensure accurate ICD-9-CM code assignment.

> **Hemorrhage . . .**
> ulcer—*see* Ulcer, by site, with hemorrhage

In the preceding example, a code cannot be assigned until the instruction that has been provided is followed. The codes under the main term "Ulcer" must be reviewed.

Often the cross-reference *see* is found under the anatomical site, directing the coder to the condition or disease affecting that site.

> **Aorta, aortic**—*see* condition

In the preceding example, the main term "Aorta" offers the instruction to "*see* condition." Therefore, a condition affecting the aorta, such as arteriosclerosis, should be sought out. The *see* instruction also is used when a condition is indexed under more than one main term.

> **Metrorrhexis**—*see* Rupture, uterus

In the preceding example, the direction is to "*see* Rupture, uterus," for a listing of codes.

See Also

The second type of cross-reference direction is *see also.* This instruction requires the review of another main term in the index if all the needed information cannot be found under the first main term.

EXAMPLE: Patient's diagnosis is osteoarthritis, localized to the hip.

Osteoarthritis (*see also* Osteoarthrosis) 715.9
distal interphalangeal 715.9
hyperplastic 731.2
interspinalis (*see also* Spondylosis) 721.90
spine, spinal NEC (*see also* Spondylosis) 721.90
Osteoarthrosis (degenerative) (hypertrophic) (rheumatoid) 715.9

Note — Use the following fifth-digit subclassification with category 715:

0 *site unspecified*
1 shoulder region
2 upper arm
3 forearm
4 hand
5 pelvic region and thigh
6 lower leg
7 ankle and foot
8 other specified sites except spine
9 multiple sites

deformans alkaptonuria 270.2
generalized 715.09
juvenilis (Kohler's) 732.5
localized 715.3

In the preceding example, the coder is instructed to "*see also* Osteoarthrosis." But first, the subterms under osteoarthritis would have to be reviewed to find an entry titled "localized." If that subterm were found, the code provided after it would be assigned. When the subterm is not found—as is the case in the preceding example—the next step is to turn to the main term "Osteoarthrosis" in the index and review its subterms to find an entry of "localized." When that entry is found, code 715.3 can be selected. The boxed note appearing under the main term "Osteoarthrosis" reminds the coder that a fifth digit is required. The final code assignment is 715.35.

See Category

The *see category* is the least-used cross-reference in the Alphabetic Index. It is an instruction to consult a specific category in volume 1 (Tabular List).

Late—*see also* condition
effect(s) (of)—*see also* condition
abscess
intracranial or intraspinal (conditions
classifiable to 324)—*see* category 326

The *see category* instruction in the preceding example refers to category 326, which provides additional information on the coding of late effects of intracranial abscess or pyogenic infection.

Exercise 1.7

Review each diagnostic statement and underline the appropriate main term. Locate the main term in the Alphabetic Index and follow all cross-references. Confirm the code in the Tabular List and enter it on the line provided.

1. Acute endomyometritis

_____

2. Metrorrhexis, nontraumatic

_____

3. Localized osteoarthritis, shoulder

_____

4. Cervical intervertebral disc prolapse

_____

5. Stenosis of endocervical os

_____

Instructional Notations

Occasionally, instructional notations appear throughout the Tabular List to clarify information or provide additional information. The following subsections describe the various types of instructional notes.

Includes Notes

Inclusion (or includes) notes are used throughout the Tabular List to further define or provide an example of a category or section. The conditions may be synonyms or similar conditions that may be classifiable to the same code. It is important to note that inclusion notes are not exhaustive; that is, not every synonym or similar condition may be listed. The notes usually list other common phrases used to describe the same condition.

Inclusion notes can appear at the beginning of a chapter or section, or directly below a category or subcategory code.

At the beginning of a chapter or section: The instructions apply to all the codes within that chapter or section.

The following inclusion note appears at the beginning of a chapter:

INFECTIOUS AND PARASITIC DISEASES (001–139)
Includes: diseases generally recognized as communicable or transmissible
as well as a few diseases of unknown, but possibly infectious, origin

The following inclusion note appears at the beginning of a section:

ISCHEMIC HEART DISEASE (410–414)
Includes: that with mention of hypertension

Directly below a category or a subcategory code: The instructions in the inclusion note apply to all codes within that range.

The following inclusion note appears below a category:

461 Acute sinusitis
Includes: abscess, empyema, infection, inflammation, suppuration — acute, of sinus (accessory) (nasal)

A point to remember: Because the inclusion note is not repeated, the coder must look back to the beginning of the subcategory, category, section, or chapter to ensure that important instructions are not missed.

Excludes Notes

The exclusion (or excludes) notes found in the Tabular List are hard to miss on review because the word *Excludes* appears in italicized print with a box around it. Exclusion notes can appear at the beginning of a chapter or section, or below a category, subcategory, or subclassification. Essentially, exclusion notes should be interpreted as a direction to code the particular condition listed elsewhere, usually with the code listed in the exclusion note.

Exclusion terms have three different meanings:

1. The most common exclusion note indicates that the code under consideration cannot be assigned if the associated condition specified in the exclusion note is present. Rather, the code specified in the exclusion note is assigned to fully identify the condition.

424.3 Pulmonary valve disorders
Pulmonic: incompetence NOS, insufficiency NOS
Pulmonic: regurgitation NOS, stenosis NOS
Excludes: *that specified as rheumatic (397.1)*

The exclusion note indicates that code 397.1, rather than code 424.3, should be assigned if the pulmonary valve disorder is specified as rheumatic.

2. The second type of exclusion note indicates that the condition may have to be coded elsewhere. The etiology of the condition determines whether the code under review or the code suggested in the exclusion note should be assigned. One or the other code is used, but not both.

> **603 Hydrocele**
> Includes: hydrocele of spermatic cord, testis, or tunica vaginalis
> *Excludes:* *congenital (778.6)*

The exclusion note indicates that a code from category 603, Hydrocele, should not be assigned if the hydrocele is congenital. Instead, code 778.6, Congenital hydrocele, is assigned.

3. The third type of exclusion note indicates that an additional code may be required to fully explain the condition. This note specifies conditions that are not included in the code under review. Should the condition specified in the exclusion note be present, the additional code should be assigned.

> **4. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS (280–289)**
> *Excludes:* *anemia complicating pregnancy or the puerperium (648.2)*

The exclusion note indicates that two codes should be assigned to code an anemia that occurs during pregnancy or the puerperium: code 648.2x, Anemia in the mother classifiable elsewhere but complicating pregnancy, childbirth, or the puerperium, to indicate that the anemia is occurring during pregnancy; and a code from chapter 4, Diseases of the Blood and Blood-Forming Organs (280–289), to indicate the specific type of anemia.

Exercise 1.8

Answer the following questions:

1. Identify the site that is excluded from code 213.0.

   _____

2. According to the inclusion note in category 555, what conditions are included in codes 555.0–555.9?

   _____

3. According to the exclusion note in category 558, what condition is assigned codes 009.2–009.3?

   _____

4. According to the inclusion note in category 056, what condition is included in codes 056.0–056.9?

   _____

5. According to the exclusion note in category 056, what condition is assigned code 771.0?

   _____

Notes

Notes appear in the Tabular List and the Alphabetic Index in all three volumes of ICD-9-CM. Some notes carry an instruction to assign a fifth digit.

831 Dislocation of shoulder

Excludes: *sternoclavicular joint (839.61, 839.71)*
sternum (839.61, 839.71)

The following fifth-digit subclassification is for use with category 831:

0 shoulder, unspecified
Humerus NOS
1 anterior dislocation of humerus
2 posterior dislocation of humerus
3 inferior dislocation of humerus
4 acromioclavicular (joint)
Clavicle
9 other
Scapula

Other notes provide additional coding instruction and also define terms.

Injury 959.9

Note—For abrasion, insect bite (nonvenomous), blister, or scratch, see Injury, superficial.

For laceration, traumatic rupture, tear, or penetrating wound of internal organs, such as heart, lung, liver, kidney, pelvic organs, whether or not accompanied by open wound in the same region, see Injury, internal.

For nerve injury, see Injury, nerve.

For late effect of injuries, classifiable to 850–854, 860–869, 900–919, 950–959, see Late, effect, injury, by type.

326 Late effects of intracranial abscess or pyogenic infection

Note: This category is to be used to indicate conditions whose primary classification is to 320–325 [excluding 320.7, 321.0–321.8, 323.0–323.4, 323.6–323.7] as the cause of late effects, themselves classifiable elsewhere. The "late effects" include conditions specified as such, or as sequelae, which may occur at any time after the resolution of the causal condition.

Use additional code to identify condition, as:
hydrocephalus (331.4)
paralysis (342.0–342.9, 344.0–344.9)

765.0 Extreme immaturity

Note: Usually implies a birthweight of less than 1,000 grams. Use additional code for weeks of gestation (765.20–765.29).

A point to remember: The appearance of a note differs, depending on the volume of ICD-9-CM in which it is located. Alphabetic Index notes are boxed and set in italic type; Tabular List notes are located at various levels of the classification system and are not boxed.

Exercise 1.9

Use the Tabular List and Alphabetic Index to answer the following questions:

1. According to the note under code 766.0, what is considered an exceptionally large baby?

   _____

2. What do the fifth digits in category 832 indicate?

   _____

3. Use the Alphabetic Index and the note following the main term "Fracture" to answer this question: Is a greenstick fracture open or closed?

   _____

4. Turn to category 250, Diabetes mellitus. What is the appropriate fifth digit for uncontrolled type I diabetes?

   _____

5. Use the Alphabetic Index and the note following the main term "Injury" to answer this question: What main term and subterm should be indexed to code the diagnosis of nonvenomous insect bite?

   _____

Multiple Coding

In ICD-9-CM, it often is necessary to use more than one code number to fully identify a given condition. A diagnostic statement that includes phrases such as "due to," "secondary to," or "with" may require multiple codes. The coder should follow the directions in the Tabular List for the use of additional codes. The Alphabetic Index may refer the coder to a combination code through the use of connecting terms. When no combination codes are available, multiple codes should be assigned to fully describe the condition.

Mandatory Multiple Coding

Certain conditions require mandatory multiple coding. In such cases, one code describes the underlying condition (cause or etiology of the condition) and the other identifies the manifestation(s). Mandatory multiple coding is identified in the Alphabetic Index with the second code listed in brackets. The first code identifies the underlying condition, and the second code identifies the manifestations or other conditions that occur as a result of the underlying condition. In such cases, both codes must be assigned and sequenced in the order listed in the Alphabetic Index.

In the Tabular List, mandatory multiple coding is indicated by the phrase "use additional code" and the code for the underlying condition. The manifestation code acknowledges the need for multiple codes with the phrase "code first underlying condition." The manifestation codes and the titles are listed in italic print. The codes in italic print can never be designated as principal diagnoses and always require a code for the underlying condition to be listed first.

Indiscriminate Multiple Coding

Multiple codes should not be used to code irrelevant medical information, such as certain signs and symptoms that are integral to a condition. The signs and symptoms that are characteristic of an illness are not coded when the causes of the signs or symptoms are known. For example, abdominal pain is integral to acute appendicitis and thus is not coded.

Indiscriminate coding of conditions listed in diagnostic test reports should be avoided. When a laboratory test, x-ray, EKG (electrocardiogram), or other diagnostic test includes a finding, that condition is not coded unless the diagnosis is confirmed by the physician.

Coders should follow the Uniform Hospital Discharge Data Set (UHDDS) criteria when reporting additional diagnoses. Often diagnostic reports mention conditions such as atelectasis, hiatal hernias, or nonspecific cardiac arrhythmias with no other information in the record as to treatment or evaluation. Assigning a code for such conditions would be inappropriate without first consulting with the physician.

Finally, coding both an unspecified and a specified type of condition is usually not done to describe the same general condition. For example, a patient with chronic maxillary sinusitis would not be identified with both codes 473.0, Chronic sinusitis, maxillary, and 473.9, Unspecified sinusitis (chronic). Code 473.0 is more specific, fully describing the patient's condition, and should be assigned.

Use Additional Code

The instructional notation "Use additional code" is found in the Tabular List of ICD-9-CM. This notation indicates that use of an additional code may provide a more complete picture of the diagnosis or procedure. The additional code should always be assigned if the health record provides supportive documentation.

If this instruction appears at the beginning of a chapter, it applies to all the codes in that chapter.

8. DISEASES OF THE RESPIRATORY SYSTEM (460–519)

Use additional code to identify infectious organism.

Sometimes it appears at the beginning of a section.

INFLAMMATORY DISEASE OF FEMALE PELVIC ORGANS (614–616)

Use additional code to identify organism such as Staphylococcus (041.1), or Streptococcus (041.0).

Finally, it also may appear in a subcategory.

530.2 Ulcer of esophagus
Ulcer of esophagus: fungal, peptic
Ulcer of esophagus due to ingestion of: aspirin, chemicals, medicines
Use additional E code to identify cause, if induced by chemical or drug

Code First Underlying Disease

The instruction "Code first underlying disease" is found in the Tabular List for categories in which primary tabulation is not intended. (See the subsection on mandatory multiple coding.) The code, title, and instructions are set in italic type to serve as a red flag not to assign that code as a principal diagnosis. The note requires listing, first, the code for the underlying disease (etiology) and, second, the code for the manifestation. Though the note will suggest underlying diseases in most instances, it is not all-inclusive because the physician may identify other causes not included in the list.

366.4 Cataract associated with other disorders
366.41 Diabetic cataract
Code first diabetes (250.5)
366.42 Tetanic cataract
Code first underlying disease, as:
calcinosis (275.4)
hypoparathyroidism (252.1)
366.43 Myotonic cataract
Code first underlying disorder (359.2)
366.44 Cataract associated with other syndromes
Code first underlying condition, as:
craniofacial dysostosis (756.0)
galactosemia (271.1)
366.45 Toxic cataract
Drug-induced cataract
Use additional E code to identify drug or other toxic substance
366.46 Cataract associated with radiation and other physical influences
Use additional E code to identify cause

Connecting Words

Connecting words are subterms that indicate a relationship between the main term and an associated condition or etiology in the Alphabetic Index. Following are examples of these subterms:

Associated with	During	Secondary to
Complicated (by)	Following	With
Due to	In	With mention of
Of	Without	

A point to remember: The connecting words "with" and "without" are sequenced before all other subterms. Other connecting words are listed in alphabetical order.

ICD-9-CM assumes a causal relationship between some combinations of conditions, even though the diagnostic statement may not make such a distinction.

EXAMPLE: Mitral valve stenosis is assumed to be rheumatic in origin and is assigned code 394.0, Mitral stenosis, from the chronic rheumatic heart disease section.

For cases where conditions often occur together, ICD-9-CM developed combination codes to identify both the etiology and the manifestation.

EXAMPLE: Streptococcal infection occurs often in the throat resulting in streptococcal sore throat. Therefore, code 034.0, Streptococcal sore throat, incorporates both the underlying disease, the streptococcal infection, and the manifestation—the sore throat.

Exercise 1.10

Using the Tabular List and Alphabetic Index, assign codes to the following:

1. Bleeding esophageal varices in liver cirrhosis

   _____

2. Urinary tract infection due to Escherichia coli

   _____

3. Acute duodenal ulcer with hemorrhage and obstruction

   _____

4. Anemia of prematurity

   _____

5. Rheumatic chorea without mention of heart involvement

   _____

Symbols, Punctuation, and Abbreviations

ICD-9-CM uses numerous symbols, punctuation marks, and abbreviations to facilitate the coding process.

Abbreviations

Two abbreviations are used in ICD-9-CM:

- NEC: Not elsewhere classifiable
- NOS: Not otherwise specified

NEC: Not Elsewhere Classifiable

NEC serves two purposes. First, it can be used with ill-defined terms listed in the Tabular List to warn the user that specified forms of the condition are classified differently. The codes given for such terms should be used only if more precise information is unavailable.

459.0 Hemorrhage, unspecified
Rupture of blood vessel, not otherwise specified (NOS)
Spontaneous hemorrhage, not elsewhere classified (NEC)

Excludes: *hemorrhage:*
gastrointestinal NOS (578.9)
in newborn NOS (772.9)
secondary or recurrent following trauma (958.2)
traumatic rupture of blood vessel (900.0–904.9)

The material in the preceding example advises to assign code 459.0 only if no other information is available. Furthermore, the exclusion note indicates that other forms of hemorrhage, such as gastrointestinal hemorrhage, NOS (578.9), are classified elsewhere.

Second, NEC can be used with terms for which a more specific code is unavailable, even though the diagnostic statement is very specific.

008.67 Enteritis due to Enterovirus NEC
Coxsackie virus
Echovirus

Excludes: *poliovirus (045.0–045.9)*

In this example, code 008.67 is reported even if a specific enterovirus such as echovirus has been identified because ICD-9-CM does not provide a specific code for it.

NOS: Not Otherwise Specified

NOS is the equivalent of "unspecified." It is used only in the Tabular Lists for both diseases and procedures. Codes describing "not otherwise specified" conditions or procedures are assigned only when the diagnostic or procedural statement, as well as the health record, does not provide enough information.

382.9 Unspecified otitis media
Otitis media:
NOS
acute NOS
chronic NOS

In the preceding example, code 382.9 is the appropriate code assignment because the diagnostic statement and/or the health record lack(s) additional information, such as purulent or serous.

Symbols

The official ICD-9-CM uses two symbols:

§ Section Mark
□ Lozenge

Section Mark §

In ICD-9-CM, a section mark symbol precedes codes in the Tabular Lists of both procedures and diseases. It indicates the presence of a footnote at the bottom of the page or references an instructional note located earlier in the section. A section mark symbol preceding a category applies to all subdivisions in that category.

§656 Other fetal and placental problems affecting management of mother

The section mark symbol preceding category 656 indicates that a footnote with an instruction to assign fifth digits printed on a previous page can be found at the bottom of the page.

A point to remember: Some publishers of ICD-9-CM have elected not to use the section mark symbol in their versions of the official coding manual, opting instead for some other symbol as an alert of special instructions.

Lozenge □

Found immediately preceding a four-digit code in volume 1, the lozenge symbol identifies the code as unique to the clinical modification of ICD-9 (or ICD-9-CM, the system used in the United States). However, this symbol does not correlate directly with ICD-9. Although researchers may find this information helpful, coders ignore it because it has no significance to their tasks. Many publishers of ICD-9-CM codebooks have eliminated this symbol from their editions.

§851 Cerebral laceration and contusion
- **□ 851.0 Cortex (cerebral) contusion without mention of open intracranial wound**
- **□ 851.1 Cortex (cerebral) contusion with open intracranial wound**
- **□ 851.2 Cortex (cerebral) laceration without mention of open intracranial wound**
- **□ 851.3 Cortex (cerebral) laceration with open intracranial wound**
- **□ 851.4 Cerebellar or brain stem contusion without mention of open intracranial wound**
- **□ 851.5 Cerebellar or brain stem contusion with open intracranial wound**
- **□ 851.6 Cerebellar or brain stem laceration without mention of open intracranial wound**
- **□ 851.7 Cerebellar or brain stem laceration with open intracranial wound**
- **□ 851.8 Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound**
- **□ 851.9 Other and unspecified cerebral laceration and contusion, with open intracranial wound**

Punctuation Marks

ICD-9-CM contains five punctuation marks with specialized meanings.

A point to remember: Some publishers of ICD-9-CM have elected not to use certain punctuation marks.

Parentheses ( )

Parentheses enclose supplementary words or explanatory information that may or may not be present in the statement of a diagnosis or procedure. They do not affect the code number assigned to the case. Terms in parentheses are considered nonessential modifiers, and all three volumes of ICD-9-CM use them.

494 Bronchiectasis
Bronchiectasis (fusiform) (postinfectious) (recurrent)
Bronchiolectasis

Excludes: *congenital (748.61)*
tuberculous bronchiectasis (current disease) (011.5)

In the preceding example, category 494 includes three nonessential modifiers enclosed in parentheses: fusiform, postinfectious, and recurrent. The presence or absence of these modifiers in the diagnostic statement has no bearing on the assignment of code 494.

Square Brackets [ ]

Square brackets are used to enclose synonyms, alternative wordings, abbreviations, and explanatory phrases. In effect, they are similar to parentheses in that they are not required as part of the diagnostic or procedural statement. Square brackets are used for both diseases and procedures, but only in the Tabular Lists.

427.0 Paroxysmal supraventricular tachycardia
Paroxysmal tachycardia:
atrial [PAT]
atrioventricular [AV]
junctional
nodal

Because they are abbreviations, PAT (paroxysmal atrial tachycardia) and AV (atrioventricular) are enclosed in brackets.

460 Acute nasopharyngitis [common cold]
Coryza (acute)
Nasal catarrh, acute
Nasopharyngitis:
NOS
Acute
Infective, NOS
Rhinitis:
acute
infective

In the preceding example, the phrase "common cold" is a synonym for acute nasopharyngitis and is enclosed in brackets.

Slanted Brackets *[ ]*

Slanted, or italicized, brackets are found only in the Alphabetic Index. They enclose a code number that must be used in conjunction with a code immediately preceding it. Thus, the code in the slanted brackets is always sequenced second.

In the Alphabetic Index to Diseases, the first code represents the underlying condition and the second code, enclosed in italicized brackets, is the manifestation.

Retinitis (*see also* Chorioretinitis) 363.20
diabetic 250.5 *[362.01]*

The sequencing of the preceding example is as follows:

250.5x Diabetes with ophthalmic manifestations
362.01 *Background diabetic retinopathy*

Colon :

The colon is used in the Tabular List after an incomplete term that needs one or more modifiers in order to be assigned to a given category or code.

204 Lymphoid leukemia
Includes: leukemia: lymphatic lymphoblastic
leukemia: lymphocytic lymphogenous

In the preceding example, the colon indicates that the type of leukemia must be lymphatic, lymphoblastic, lymphocytic, or lymphogenous to be assigned a code from category 204.

Brace }

Braces simplify tabular entries and save printing space by reducing repetitive wording. They connect a series of terms on the left or right with a statement on the other side of the brace. A term from the left must be associated with the term on the right before the code under consideration can be assigned.

INTERNAL INJURY OF THORAX, ABDOMEN, AND PELVIS (860–869)
Includes: blast injuries
blunt trauma
bruise
concussion injuries (except cerebral)
crushing
hematoma
laceration
puncture
tear
traumatic rupture
} of internal organs

Without the brace, the narrative would take up space and prove hard to read, as shown below:

blast injuries of internal organs
blunt trauma of internal organs
bruise of internal organs
concussion injuries (except cerebral) of internal organs,
and so forth

Exercise 1.11

Using the Tabular List and Alphabetic Index, assign codes to the following:

1. Anterolateral wall myocardial infarction, initial episode

   _____

2. Angiodysplasia of stomach and duodenum, no hemorrhage noted

   _____

3. Tuberculous iritis

   _____

4. Primary malignant neoplasm of the spleen

   _____

5. Fifth disease

   _____

Basic Steps in ICD-9-CM Coding

To code each disease or condition completely and accurately, the coder should:

1. Identify all main terms included in the diagnostic statement.
2. Locate each main term in the Alphabetic Index.
3. Refer to any subterms indented under the main term. The subterms form individual line entries and describe essential differences by site, etiology, or clinical type.
4. Follow cross-reference instructions if the needed code is not located under the first main entry consulted.
5. Verify the code selected in the Tabular List.
6. Read and be guided by any instructional terms in the Tabular List.
7. Assign codes to their highest level of specificity.
   - —Assign three-digit codes only when no four-digit codes appear within the category.
   - —Assign a fifth digit for any subcategory where a fifth-digit subclassification is provided.
8. Continue coding the diagnostic statement until all the component elements are fully identified.

Review Exercise: Chapter 1

Using the instructions and conventions introduced in chapter 1, assign the appropriate codes to the following:

1. Acute appendicitis with perforation

   _____

2. Streptococcal pneumonia

   _____

3. Chest pain, originating in chest wall

   _____

4. Acute cor pulmonale

   _____

5. Osteoarthrosis, localized, primary of ankle

   _____

6. Toxic nodular goiter with crisis

   _____

7. Extra thyroid gland

   _____

8. Angiodysplasia of the colon with hemorrhage

   _____

9. Acute tracheobronchitis with bronchospasm

   _____

10. Arteriosclerotic heart disease of native coronary artery with angina

    _____

11. Nephrotic syndrome secondary to systemic lupus erythematosus

    _____

12. Prenatal care, normal first pregnancy

    _____

13. Comminuted fracture of femur involving the subtrochanteric section

    _____

14. Prostatitis due to Trichomonas

    _____

15. Carotid artery occlusion with cerebral infarction; essential hypertension

    _____